IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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June 10, 2009

Thair Pond
Tomorrow's Hope - Sapphire
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Sapphire, provider #13G038

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Sapphire, which was conducted on June 3, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 23, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 23, 2009. If a request for informal dispute resolution is received after June 23, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G038	A. BUILDING _____ B. WING _____	06/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - SAPPHIRE	2154 SAPPHIRE PLACE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactive Disorder IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED JUN 22 2009 FACILITY STANDARDS	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, a review of the Professional Intervention Checklists, and staff interview it was determined the facility failed to adequately develop policies necessary to provide sufficient assessment of individuals with suicidal ideation for 1 of 3 individuals (Individual #1) whose records were reviewed, and had the potential to impact 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in assessment of suicide risk being delegated to staff. The findings include: 1. Individual #1's 11/14/08 IPP stated he was a 16 year old male whose diagnoses included ADHD, mood disorder, intermittent explosive disorder, and moderate mental retardation. Individual #1's	W 149	W149 Policy and Procedures changed to reflect procedures that allow the delegating of completing the Professional Intervention Checklist to Techs and assigned staff. Instructions for implementing behavior intervention has been corrected to be clear to staff. staff trained on instructions QMRP AND Program Director responsible by 06/20/09 Policies and procedures corrected to reflect usage of assigned staff to complet the Professional Intervention Check list. Polices to be reviewed by Management Audit Team at least yearly to ensure they reflect the current policies and prodedures Behavior plans will be reviewed before implementation and at Monthly QA at least Quarterly to ensure instructions to staff are clear and spedific. QMRP and Program Director responsible by 07/08/09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thair Pond	Administrator	06/19/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 record documented he engaged in suicidal ideation, including making both statements and gestures of self harm. The facility's Treatment of Clients/Residents policy, revised 11/08, defined abuse as "violation, revilement, malignment [sic], exploitation, and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator." The policy further defined neglect as "failure to provide goods or services necessary to avoid physical or psychological harm." The facility's Suicide Policy, revised 8/5/04, stated "It is [facility name] policy to provide a safe environment for our residents and provide protection from harm from themselves or others. [Facility name] shall adhere to the following procedures to ensure residents are safe from suicide or attempted suicide." The Suicide Policy contained a definition for Acutely Suicidal as "the person is on the verge of self-harm or suicide (e.g. a cord is around their neck already)." The directions provided in the policy stated professional staff were to come in to the facility and provide support, instruction, investigation, notification of parents/guardians, assess the situation, complete the Professional Intervention Checklist, and remain until the situation and individual were under control. Individual #1's record contained 12 Professional Intervention Checklist forms, dated from 7/10/08 - 5/28/09. Ten of the 12 forms documented Individual #1 actually wrapped an item (i.e., drapes, clothing, belt) around his neck in an effort to cause self harm. All 10 of those forms were	W 149		

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W 149	Continued From page 2 completed by non-professional staff. When asked during an interview on 6/3/09 from 11:30 a.m. - 12:45 p.m., the QMRP stated Individual #1's wrapping items around his neck met the Suicide Policy's definition for Acutely Suicidal. The QMRP stated, per policy, professional staff should have completed the Professional Intervention Checklists rather than delegating to non-professional staff. The QMRP stated the policy needed to be revised. The facility failed to ensure the Suicide Policy was implemented for Individual #1.	W 149		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 1 of 3 individuals (Individual #1) whose behavior management plan was reviewed. This resulted in a lack of instructions to staff being included in an individual's program. The findings include: 1. Individual #1's 11/14/08 IPP stated he was a 16 year old male whose diagnoses included ADHD, mood disorder, intermittent explosive disorder, and moderate mental retardation. Individual #1's record contained a Behavior Intervention Plan, dated 2/24/09, titled "Suicide actions." The plan stated Individual #1 had a history of suicidal statements and gestures that	W 234	W234 Behavior Intervention Plan has been corrected to provide clear and specific instructions to staff on how to intevene during suicidal ideation. Staff have been trained on specific instructions QMRP responsible by 06/19/09 Identified behavior Intervention Plan has been corrected. New Behavior intervention plans will be reviewed by IDT to ensure clear instructions to staff are included. Behavior intervention plans to be reviewed at Monthly QA QMRP and Program Director responsible	

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W 234	Continued From page 3 included wrapping belts, cords and ropes around his neck and pulling on the ends as if to strangle himself. He had also held a butter knife to his neck and used broken plastic to scrape his arms. Individual #1's Behavior Intervention Plan did not provide specific instructions to staff regarding protective measures during suicidal actions as follows: a. Individual #1's Behavior Intervention Plan stated any time he acted on a suicidal statement by placing something around his neck or attempting to cut himself, staff were to remove "the object he is using." However, the plan did not include instructions to staff regarding other items in the environment Individual #1 could use to harm himself. Eight direct care staff were interviewed on 6/1/09 from 3:45 - 4:50 p.m., and on 6/2/09 from 9:30 - 10:20 a.m. When asked what items were to be removed from Individual #1's bedroom following a suicidal gesture, staff stated the following: - One staff stated any similar item was to be removed from the room, but only if it belonged to Individual #1. The staff stated items belonging to Individual #4, who roomed with Individual #1, could not be removed. - One staff stated any similar item belonging to Individual #1 was removed from the room, and staff were to stay in the bedroom and block Individual #1 from accessing Individual #4's belongings. - One staff stated all similar items in the room were to be removed, regardless of who they belonged to. - The remaining 5 staff stated the item being used by Individual #1 during the gesture was to be	W 234		

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W 234	Continued From page 4 removed, but were not sure if other items should be removed from the room. When asked during an interview on 6/3/09 from 11:30 a.m. - 12:45 p.m., the QMRP stated Individual #1's Behavior Intervention Plan did not provide clear directions to staff on what items needed to be removed to ensure Individual #1's safety during suicidal ideation. b. Individual #1's Behavior Intervention Plan stated any time he acted on a suicidal statement he was to remain "line of sight for an hour after the incident. [Individual #1] appears calm and goes to his room and closes the door, staff will check on him every 3 - 5 minutes." Staff would not be able to maintain line of sight for one hour after an incident while Individual #1 was in his room with the door closed. When asked during an interview on 6/3/09 from 11:30 a.m. - 12:45 p.m., the QMRP stated the statement in Individual #1's Behavior Intervention Plan was contradictory and staff could not maintain line of sight with Individual #1's door closed. The facility failed to ensure Individual #1's Behavior Intervention Plan contained clear and specific instructions to staff on how to intervene during suicidal ideation.	W 234		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior.	W 276		

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W 276	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, policy and procedure review, record review, and staff interview it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior. This failure impacted 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in interventions being used without the necessary facility approvals. Findings include: 1. The facility housed 6 males ranging in age from 11 to 19. During observations at the facility on 6/1/09 from 3:45 - 4:50 p.m. and 5:25 -6:10 p.m., and on 6/2/09 from 6:15 - 7:50 a.m. and 9:30 - 10:20 a.m., an alarm was noted to be connected to the front door. Each time the door was opened, the alarm would sound. All staff present during the observations stated Individual #1 had a history of running out of the facility. The facility's Treatment of Clients/Residents policy, revised 11/08, included the facility's approved interventions to manage inappropriate behavior. The Treatment of Client's/Residents policy did not include the use of door alarms. When asked during an interview on 6/3/09 from 11:30 a.m. - 12:45 p.m., the QMRP stated door alarms were not included in the policy but should have been. 2. Individual #2's 3/3/09 IPP stated he was an 11 year old male whose diagnoses included autism and profound mental retardation. During an observation on 6/1/09 from 3:45 - 4:50	W 276	W276 Door alarms and blocking have been added to the policy and procedures as an approved behavioral intervention. Program Director responsible by 06/19/09 Door alarms and blocking have been added to policy and procedures as approved behavioral interventions. QMRP and Program Director will ensure new Behavioral interventions meet policy and procedures guidelines. Behavioral interventions used will be reviewed during monthly QA and at least Quarterly to ensure compliance. QMRP and Program Director responsible by 06/19/09	

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W 276	Continued From page 6 p.m., Individual #2 was observed to strike out at staff, hitting and attempting to grab onto clothing. Individual #2 was cued to take a break to calm in his bedroom and staff walked with Individual #2 to his bedroom. Once there, Individual #2 continued to swing his fists towards staff. The staff, who was standing in the doorway, was holding a large pillow which Individual #2 hit, and cued Individual #2 to take deep breaths. The staff told Individual #2 he needed to calm down before leaving his room and remained in the doorway blocking Individual #2 from leaving his room. Individual #2's "Taking a break" program, dated 3/26/09, stated staff were to stand in Individual #2's doorway and use their body to block his aggression and exit from his bedroom, and stated staff may used a pillow to block his aggression. The facility's Treatment of Clients/Residents policy, revised 11/08, included the facility's approved interventions to manage inappropriate behavior. The Treatment of Client's/Residents policy did not include blocking individuals exit from the bedrooms as a behavioral intervention technique. When asked during an interview on 6/3/09 from 11:30 a.m. - 12:45 p.m., the QMRP stated blocking individuals from leaving their bedrooms was not included in the policy but should have been. The QMRP stated the policy was under revision. The facility failed to ensure all approved behavioral interventions were included in the policy.	W 276		

Bureau of Facility Standards

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177	MM177 refer to tag W149	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include: During an environmental survey conducted on 6/2/09 from 2:00 - 2:35 p.m., the following concerns were noted: Individual #5 and Individual #6's bedroom: - The caulking around the window was peeling and missing in several sections.	MM380	MM380 Identified deficiencies will be cleaned, repaired, or replaced as needed. Identified deficiencies and corrections will be reviewed at Monthly QA Para Q responsible by 7/08/09 RECEIVED JUN 22 2009 FACILITY STANDARDS	

Bureau of Facility Standards

Chas S Rm

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 06/09/09

Bureau of Facility Standards

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MM380	Continued From page 1 Individual #3's bedroom: - The door was missing paint in several sections. - There were crayon marks across one wall. - There was a 3 inch "L" shaped hole in the wall behind the door, and the paint was peeling around the hole. Individual #2's bedroom: - A patched section of wall to the right of the window was missing paint. - There was an 8 inch tear and a 6 inch tear in the vinyl cover of the banana chair. - There was a thick layer of dust on the television and television stand. - There was an unknown spill in the shoe basket in the closet. Individual #1 and Individual #4's bedroom: - The caulking around the window was peeling and missing in several sections. - The wallboard to the left above the window was cracked and broken. - The wallpaper border was ripped and peeling.	MM380		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520	MM520 Refer to Tag W276	

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MM855	Continued From page 2	MM855		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855	MM855 refer to Tag W234	